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Out of the silence: towards grassroots and trauma-informed support for people who have experienced sexual violence and abuse

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Introduction

> trauma matters. It shapes us. It happens all around us. It destroys some of us, and it is overcome by many of us. To ignore it is to ignore who we are in all our complexity (Filson, 2016).

Inter-personal trauma has at its core the abuse of power (see Lovett et al. 2018). This paper focuses on power abuses that manifest as sexual violence in all its subtleties and complexities, whilst understanding that many survivors have experienced multiple forms of abuse over long periods meaning that their experiences often do not map neatly onto the distinct categories used in research and practice (Perôt & Chevous, 2018). We also write in the knowledge that it can take people many years to understand that what they have experienced constitutes sexual violence.

Estimates of the prevalence of childhood sexual abuse range from one in 20 to as high as one in four, with girls disproportionately affected (Felitti et al. 1998; Radford et al. 2011). Globally, it is estimated that 35% of women have experienced sexual or intimate partner violence, and that women are more likely to experience repeated and severe violence compared to men (Oram et al. 2017). Experiencing sexual violence is linked to significant mental distress (Khadr et al. 2018), with childhood sexual abuse (CSA) in particular linked to psychosis (Bebbington et al. 2011). Unsurprisingly, current and previous rates of sexual violence amongst people in contact with psychiatric services are high (e.g. Grubaugh et al. 2011; Mauritz et al. 2013; Khalifeh et al. 2015). Given that sexual violence is so commonplace and so impactful, what is psychiatry's response?

Mainstreaming silence: psychiatric services and sexual violence

> The idea that people, predominantly girls and women, are too mad, too bad and too sad to be believed has been used to silence people since time immemorial (Watts, 2018).

Silence typically characterises the experience of sexual violence, particularly in childhood. It is a silence that is demanded and coerced by perpetrators, and sanctioned by families, communities and

society. Sexual violence survivors have long described the way in which psychiatry can reinforce this silence, causing further harm to an already shattered self (e.g. Smith et al. 2015; Bond et al. 2018). Collectively, we may recognise the silencing of the past, of the wives and daughters placed in Victorian asylums. But we deny the silencing of the present, for psychiatry is different now, not like the representations of One Flew Over the Cuckoo's Nest, but benign, expert, well-meaning. We may concede that psychiatry silenced sexual violence survivors in the 1960s, maybe even the 1970s, but surely not now.

The experiential knowledge of survivors, shared in conversations, blogs, book chapters and beyond reveals a different story.

> I broke down completely. My internal distress was mirrored by my external reality. I was in a seemingly endless nightmare and I was awake … It didn't take long for the label of 'paranoid schizophrenic' to be pronounced over my dead spirit. I was tendered a large dose of Largactil … to appease my reality (Richie B, 1996 pp 12).

> My first contact with mental health services was at the age of 12 or 13. Although I didn't have the words to explain what had happened to me, after years of silence, and of feeling that I didn't have a voice, my story was pouring out. I was closed down with medication and changes of topic. I still do not have the words to tell my story. Twenty years earlier, my mum's trauma had led her to sectioning, ECT and a lifetime of contact with mental health services. I believe that our lives would have unfolded very differently if … staff had been supported to understand and engage with our pain - if we were encouraged to tell our stories instead of being shut down with looks, words, drugs and ECT (Sweeney, 2016).

It is only in recent years that mainstream mental health research has established the role of gender-based violence in the development of significant mental distress (e.g. Bebbington et al. 2011; Kahdr et al. 2018); this partially explains the paucity of research eliciting survivors' views of support needs and services. Sexual violence survivors may justifiably expect that psychiatric services have a long-held fundamental understanding of trauma and sexual violence, how it impacts on people, and survivors' subsequent support needs. It often comes as a shock when survivors attempt to access help and realise that not only is there very little well-funded support available, but that the response of psychiatry can be actively harmful (Smith et al. 2015; Bond et al. 2018). This can leave desperate people with a choice between harmful help, or no help (Jensen, 2004, quoted in Russo, 2018 p. 10).

Further, asking for help with nothing changing can replicate damaging early experiences (e.g. see Bond et al. 2015).

What do we mean when we describe psychiatric help as harmful? It is not uncommon, even in the #MeToo era, for sexual violence survivors to be disbelieved by psychiatric services, to be explicitly told "You were not abused, you have a mental illness" (see also Hughes et al. this issue). Russo writes, "psychiatry is one of the best preventions of truth … becoming a mental patient was a good solution for everyone, except for me" (2002). Research has found that mental health staff often fail to validate disclosures because service users have psychiatric diagnoses (Mantovani & Allen, 2017), and frequently use 'alleged' when recording disclosures in medical notes (Trevillion et al. 2014), a subtle form of silencing. Alongside inflicting immense psychological damage, denying sexual violence jeopardises criminal proceedings and risks keeping people in abusive situations.

Connected to this, the power and authority of biomedical psychiatric interpretations of mental distress can delegitimise people's own knowledge:

> I knew that what I was experiencing made sense, given what had taken place in my life. Even then I understood my reactions as sane responses to an insane world. I was told, 'Whatever else might be going on with you is not relevant – it's your mental illness that matters'. This drove me into a frenzy, for now help was just another perpetrator saying, 'You liked it, you know you did; that wasn't so bad; it's for your own good.' I was diagnosed and described as 'lacking insight' – ensuring that I would never be able to legitimately represent my self or my own experiences (Filson, 2016 pp. 21).

Whilst experiences of diagnosis are idiosyncratic, receiving a diagnosis can operate as a powerful signifier that it is you who are the problem, not your experiences, reinforcing silence. The label 'personality disorder', for instance, locates the problem within the individual and de-legitimses the search for meaning in one's responses to, and interaction with, the social world (Coles, 2013). Watson has observed, "What messages is society giving to abusers when victims are given disorders as the explanation for distress?" (2018). Similarly, Shaw and Proctor comment:

> I cannot understand how the vast majority of perpetrators of sexual violence walk free in society; whilst people who struggle to survive its after effects are told they have disordered personalities (cited in Coles, 2013).

Prominent psychiatrist and trauma researcher Judith Herman argues that help is always harmful when it mimics the original trauma by taking power away from the survivor (1997). Everyday experiences of using psychiatric services can re-traumatise survivors and actively prevent healing. Consider the use of restraint and forcible injection, which can physically re-enact rape and sexual assault. Agenda, a UK-based non-governmental organisation, has found that one in five women and girls admitted to UK psychiatric units experience physical restraint, including repeated and face down, and that women and girls are more likely to be restrained than men and boys (2017).

> It was horrific… I had some bad experiences of being restrained face down with my face pushed into a pillow. I can't begin to describe how scary it was, not being able to signal, communicate, breathe or speak. Anything you do to try to communicate, they put more pressure on you. The more you try to signal, the worse it is (MIND, 2013).

The damage inflicted by 'power over' responses to distress also takes subtler forms, including overt and insidious pressures to accept prescriptions, treatments and diagnoses that may conflict with people's own beliefs and needs. This replication of invalidation, coercion and force can be hugely damaging, not only to survivors but also to staff, particularly those who are themselves survivors: research suggests that there are significant trauma rates amongst health and social care staff (e.g. Bracken et al. 2010; Esaki & Larkin, 2013; McLindon et al. 2018). This is because the organisational expectation that staff will use 'power over' relational approaches can erode staff compassion (Sweeney et al. 2016), with pessimism - rather than hope – protecting staff from feelings of helplessness (Chambers et al. 2014). Biomedical dominance, insufficient support and training in sexual violence and trauma-informed approaches, and inconsistent access to structured, reflective supervision can act as further barriers to compassionate responses to sexual violence survivors (see Sweeney et al. 2018). Furthermore, it is difficult for staff to face and accept the scale and horror of sexual violence and abuse without support (see Sweeney et al. 2018). Bond and colleagues interviewed 28 CSA survivors, and found:

> All the survivors who spoke to us described numerous encounters with support services that demonstrated an innate lack of empathetic understanding, professional knowledge and expertise in how best to provide appropriate support for adult survivors of CSA (2018).

Sexual violence within psychiatric settings

Perpetrators of sexual violence are able to operate in institutions where organisational cultures reinforce silence; where there is a "conducive context" (Lovett et al. 2018). Following a recent investigation into the aid sector, the parliamentary International Development Committee concluded:

> the delivery of aid, whilst providing lifesaving resources to people and communities in crisis, can also be subverted by sexual predators into a channel through which they can magnify their power and use possession of those resources to exploit and abuse some of the most vulnerable people in the world. We must not turn away from the horror of it. We have a duty to confront it. (2018 pp. 75).

Psychiatric service users are also vulnerable to institutional sexual exploitation and violence, not least because psychiatric labels can undermine claims to truth and rationality (Roper, 2016; Rose, 2017). The few studies that have been conducted into sexual violence on inpatient wards are deeply troubling. A survey of 50 women in Australia found that 45% had been sexually assaulted whilst an inpatient, and of the 61% who reported this to staff, the overwhelming majority (85%) found the response unhelpful (VMIAC, 2013). One participant commented "If the assailant is not a patient but a nurse or doctor who can you trust or turn to for help?". A recent investigation by England's Care Quality Commission found that on inpatient psychiatric wards over a 3 month period in 2017, there were reports of 29 rapes, 273 sexual assaults and 184 acts of sexual harassment, the majority against service users (2018). The report also concluded that recording rates may be low, partially due to staff desensitisation through the regularity of incidents (see Hughes et al, this issue, for further discussion). Police recording of sexual assaults on psychiatric inpatient wards has also been found to be inadequate (Foley & Cummins, 2018). Whilst the UK has a policy of gender segregation on inpatient psychiatric wards, this cannot protect people from sexually violent staff, or perpetrators of the same gender.

Out of the silence: grassroots and community-based responses

The UK has few statutory services for sexual violence survivors (Coy et al. 2009; Allnock et al. 2012; Kennedy et al. 2015; Hawkins & Taylor, 2015), with National Health Service trauma clinics often excluding experiences of childhood abuse. This, coupled with experiences of statutory iatrogenic harm, means that many survivors are seen in community-based specialist sexual violence services (Bond et al. 2018). Despite survivors' generally reporting positive experiences of these services

(Bond et al. 2018), they are often underfunded, resulting in long waiting lists, session fees and time-limited therapy (Smith et al. 2015). It is also uncommon for the sector's specialist expertise to impact on psychiatric services: indeed, there are concerns that the direction of influence runs the other way, with a psychiatric 'creep' into anti-violence services, such as the increasing tendency to establish separate services for the 'mentally ill' (Rubinsztajn, 2016).

Survivors who have experienced pathologisation and iatrogenic harm often move away from helper-helpee roles, connecting instead through mutual peer support (e.g. Filson & Mead, 2016). Some survivors have established organisations fostering peer support, self-help, activism, campaigning and education, often simultaneously. In the UK, these include Survivors' Voices (co-established/led by CP, www.survivorsvoices.org), Butterfly (established by VA, http://focus-4-1.co.uk/projects-services/) and The Survivors' Collective (www.survivorscollective.co.uk). There are also important transnational sources of influence and inspiration. Endeavours like these are often run with little or no funding, reliant instead on the passion and commitment of key members.

In reflecting on a Berlin-based survivor-led sexual violence project, Rubinsztajn observes:

> how powerful it can be when people realise that *everybody* else in the project is a survivor … It's then, maybe for the first time, that the person is consciously in a space with other survivors and can physically grasp that they're not alone in their experience … you find yourself among likeable, tough and funny people who have gone through similar things and decided not to bear those experiences and consequences on their own anymore, not to stay silent anymore (emphasis added, pp. 128).

Carr writes of, "the persistent argument from service users, survivors, their organisations and communities … that we must have independent organisations, arenas and power bases from which to think and do for ourselves" (2018). Rubinsztajn also voices concerns that survivor-led sexual violence projects can come to mimic the mainstream services they critique; she describes the lack of a single 'we' in survivors' needs and perspectives, with some experiences highlighted and others unspoken, such as of racism. Adopting an intersectional approach is a shared core standard for a number of women's anti-violence services, benchmarking good practice (Imkaan et al. 2016).

The hope of trauma-informed approaches

> The behaviours and thoughts that experts in some cultures label psychotic or schizophrenic are usually understandable reactions to our life events and circumstances. So rather than ask, "What is wrong with you?" and "What shall we call it?" It is more sensible, and useful, to ask, "What happened to you?" and "What do you need?" (Read, 2018).

Trauma-informed approaches may be a way of enabling all services – community and statutory alike - to come closer to meeting survivors' needs, as well as improving staff experiences (e.g. see Sweeney et al. 2018). Trauma-informed approaches are an organisational change process that can be described as:

> a strengths-based framework that is grounded in an understanding of, and responsiveness to, the impact of trauma, that emphasises physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment (Hopper et al. 2005).

The aim then, is to improve experiences, relationships and environments for staff and service users. Whilst concepts like 'strengths-based' and 'empowerment' can seem almost meaningless because of their overuse, they are hugely significant in this context, intended to reverse the 'power over' abuses that are at the heart of sexual violence and iatrogenic harm (see Butler et al. 2011; Sweeney et al. 2016).

Fundamental to trauma-informed approaches is 'seeing through a trauma lens' – that is, understanding the connections between experiences and coping strategies - and preventing (re)traumatisation. Although further principles have been fairly well described (see, for example, Elliot et al. 2005; Butler et al. 2011; SAMSHA, 2014; Filson, 2016; Sweeney et al. 2016), the approach is relatively complex and consequently, commonly misunderstood (Sweeney & Taggart, 2018). This increases the risk that where implemented, it could be diluted to the point of worthlessness (Sweeney & Taggart, 2018). Change is required at a systemic level, including staff support, training and reflective supervision (Bloom, 2016). Alongside commissioning meaningful trauma-informed services (Bush, 2017), commissioners should develop and strengthen peer-led organisations, reinforcing local capacity to engage in service provision, peer support and campaigning (e.g. Bott et al. 2010).

Despite widespread interest in, and early implementation of, trauma-informed approaches, there is a lack of underpinning empirical research (see Chritie, 2018). And just as there are vast differences between grassroots and mainstream psychiatric services, so too there are vast differences between survivor-led and mainstream research approaches (e.g. see Russo, 2012). Research led by and co-produced with survivors is needed to understand whether and how services meet survivors' needs, and to investigate the potential - and potential failings - of trauma-informed approaches. This research should itself be trauma-informed (Shimmin et al. 2017) and occur within an epistemic injustice framework (understanding discrimination and exclusion in knowledge generation and against knowers) (Fricker, 2007), with an understanding of how participation affects survivor researchers, particularly when working in partnerships (Roper, 2016). The Charter for Organisations Engaging Survivors in Projects, Research & Service Development, currently being piloted, aims to provide a quality mark for safe, meaningful and effective survivor involvement in research (Perôt & Chevous, 2018).

Closing thoughts

Survivors of sexual violence and abuse can feel let down over and over again – that the abuse was able to continue for so long; that perpetrators are able to continue abusing, including within psychiatric services; that the criminal justice system is stacked in perpetrators' favour (as evidenced by low conviction rates, Walby & Allen, 2004); and that the psychiatric system, which should understand and support survivors, is more often harmful and pathologising of individual responses, rather than recognising people's strengths and remarkable ability to adapt and survive. It is through validation (the act of believing) that a climate of support and recognition for victims and survivors of sexual violence and abuse is created. Our core belief, and one that is worth repeating, is that the expertise about what we need to heal lies with us.

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Conflict of Interest

None

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